



**HEALTH POLICY INSTITUTE  
OF OHIO**

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## **Mapping Health Spending and Insurance Coverage in Ohio**

### **AGENDA**

Columbus Public Health Department  
Main Auditorium  
240 Parsons Avenue  
Columbus, Ohio

Thursday, May 3, 2007  
11:45 a.m. to 1:45 p.m.

**11:45 a.m. Registration & Lunch**

**12:00 p.m. Welcome & Opening Remarks – William D. Hayes, Ph.D.**, President  
Health Policy Institute of Ohio

**12:05 p.m. Presentations:**

*Costing of Ohio's Non-Institutional Health System and Covering the Uninsured*  
**Jack Meyer, Ph.D.**, Principal, Health Management Associates

### **Questions & Dialogue**

*Strategies for Covering Ohio's Uninsured*  
**Barbara Edwards**, Principal, Health Management Associates  
**Greg Moody**, Principal, Health Management Associates

### **Questions & Dialogue**

**1:45 p.m. Concluding Remarks – William D. Hayes, Ph.D.**

*The Health Policy Institute of Ohio hosts policy forums that provide a neutral setting where key health issues affecting Ohioans can be explored thoughtfully and where informed dialogue – not debate – is encouraged and supported*



## About the Panelists

### Mapping Health Spending and Insurance Coverage in Ohio

May 3, 2007

**Jack A. Meyer, Ph.D.** is a principal with Health Management Associates in the Washington, D.C. office. In this capacity, Dr. Meyer is conducting health care research, policy analysis, and strategic planning for HMA clients in the mid-Atlantic region and around the nation. He is working with grant-making foundations, health industry leaders, and state and federal agencies. Dr. Meyer is also the founder and president of the Economic and Social Research Institute, a nonprofit research organization. General areas of recent and current work include: evaluation of new models to reduce the number of uninsured nationwide; comparative analysis of major policy alternatives to cover the uninsured in California, Connecticut, Maryland, and Delaware; analysis of the ingredients of hospital quality and patient safety; research on the cost to states of mental illness; assessment of states' programs to support employer-sponsored health coverage for lower-income workers; and review of promising models for improving access to health services for vulnerable populations.

**Barbara Couler Edwards** has over 25 years of public and private sector experience in health care financing and is a nationally recognized expert in Medicaid policy, including managed care, cost containment, long term care, and state and federal reform. Ms. Edwards is a frequent national presenter on Medicaid trends, Medicare Part D, and state health policy challenges. She has extensive experience in leading strategic planning and organizational change initiatives in public agencies. Prior to joining HMA, Ms. Edwards served 8 years as director of Ohio's \$12 billion Medicaid program. She served on the federal State Pharmacy Assistance Program Transition Commission regarding implementation of Medicare Part D, served on the National Quality Forum Steering Committee which recommended standards for nursing home care, and was vice chair of the National Association of State Medicaid Directors. Ms. Edwards has testified before both the U.S. Senate Finance Committee and the U.S. House Energy and Commerce Committee regarding state Medicaid and SCHIP programs.

**Greg Moody** is a senior consultant with Health Management Associates with over ten years of state and federal government experience in health policy planning, budgeting, program development, and constituent relations. Prior to joining HMA, he served as the senior health and human services advisor to the Governor of Ohio. Mr. Moody began his public service career in Congress where he worked as budget associate for the Vice Chairman of the House Budget Committee. He later served as Chief of Staff to the Dean of the Ohio State University College of Medicine and Public Health.

# Covering the Uninsured in Ohio: Mapping the Terrain, Exploring Policy Options

*Presentation to Health Policy Institute of Ohio*

Jack A. Meyer

Health Management Associates

## Study Methodology

- Interviews with more than 20 Ohio leaders
- Data analysis to estimate spending in Ohio and the cost of the uninsured
- Review of lessons from other states
- Policy analysis based on interviews, lessons, and HMA experience

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## Highlights of Stakeholder Interviews

- Build in need to improve quality and efficiency
- Bring younger, healthier people into the system
- Build on the job-based system and support it
- A public/private solution is practical and feasible
- Emphasize strategies to achieve healthy behavior
- Major Medicaid expansion is unlikely
- There is little support for a single payer system, which some like but few think is viable now

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## Scope of the Problem

- 1.3 million people in Ohio are uninsured
- This is about one of eight state residents
- About \$62 billion spent on health care for the non-institutional population in Ohio
- Many people under-insured as well
- About 45 million uninsured in U.S.
- \$2.3 trillion health care system

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## The Problem is Getting Worse

- Employer coverage is eroding
  - ◆ Offer rate is falling
  - ◆ 98% of large firms offer, but only 59% of smaller ones
  - ◆ Acceptance rate is also declining
- Medicaid expansion has slowed
- Exploding costs feed the problem
- U.S. spending above other countries and the level predicted by our wealth
  - ◆ \$477 billion in “excess” spending (McKinsey)
  - ◆ this amounts to 21% of total spending

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## Quality and Safety Problems Abound and Must be Improved

- Only 55% of care is recommended
- 34% of U.S. chronic care patients report medical errors, more than other nations
- Medication errors, hospital infections rampant
- 17% of doctors use EHRs (80% in top 3 countries)
- Only 49% of adults get preventive and screening tests according to guidelines
- Behavior and lifestyle contribute to the problem

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## International Comparisons

- U.S. is a world leader in both basic research and advanced medical technology
- We also have shorter waiting times
- But medical errors higher than any other industrialized peer
- We rank 28<sup>th</sup> in infant mortality, controlling for race
- Longevity is lower than in many nations
- We have the fewest people of any peer nation who have had the same doctor for more than 5 years

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## How Ohio Ranks

- Ohio ranks 3<sup>rd</sup> highest nationally in spending on nursing homes
- Ohio ranks 47<sup>th</sup> in health spending on kids
- About a quarter of Ohioans smoke, the fifth worst in the nation.
- About a quarter of Ohioans are obese, ranking 10<sup>th</sup> worst.

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## How Ohio Ranks

- With 216.4 cancer deaths per 100,000 each year, Ohio ranks 8<sup>th</sup> worst nationally
- 10% of Ohioans suffer from diabetes, higher than the national average
- Public health spending per capita in Ohio is \$127, about half of PA's level and less than national avg.
- Ohio is in the middle of the pack (27<sup>th</sup>) on an amalgamated quality of care measure

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## Mental Health is a Serious Problem

- In Ohio, about 2.5 million people experience a mental disorder annually
- About 20% of this group, or 500,000 people, suffer from a severe mental disorder
- Ohioans pay an estimated \$6.5 billion for the direct and indirect cost of mental illness
- Mental illness is emblematic of the need for early intervention, integration of primary and specialty care, and coordination across multiple state agencies.

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## Key Report Findings for Ohio

- Ohio spends \$31 billion per year, or about half of all spending, through employer coverage
- Ohio spends \$3.5 billion directly on the 1.3 million uninsured
- Uninsured pay 27% of this out of pocket
- Providers donate 15% of the cost of care for the uninsured through uncompensated care
- Another \$2.1-\$5.8 billion in economic losses from poor health (e.g. absenteeism, lost productivity)

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## The Cost of Covering the Uninsured

- To cover everyone, health care spending would increase by 6%
- This amounts to an additional \$3.87 billion/year
- HALF the cost of the uninsured is already in the system, much arising from neglect and delay
- The cost of covering the uninsured is bringing them up from their current spending to the level of resources used by the rest of us

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## Doing Nothing is Not Free

- 18,000 deaths per year from no insurance
- Nationwide, economic losses amount to as much as \$205 billion, according to IOM
- Physicians, hospitals and others go unpaid
- Uninsured forgo preventive care that piles up costs later in the ER and hospital admissions
- Some unpaid bills are shifted to business and labor

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## Policy Analysis: Key Elements

- Target populations
- Design of new subsidies
- Benefits
- Source of insurance (mechanism)
- Whether coverage remains voluntary
- Financing

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## Preliminary Policy Options

- HMA has developed three sets of policy options for covering the uninsured
- The goal is to inform the debate and jump-start deliberations
- Options can be revised, mixed, matched
- Option sets flow from incremental to comprehensive
- Start by building on the current system

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## Getting Started: Shoring Up the Private Insurance System

- Extend coverage to young adult children
- Build a high-risk pool for “uninsurable” people
- Insurance rating reforms to foster affordability
- Reinsurance
- Premium assistance
- Buy-in to state employees’ plan

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## Expansion of Subsidy Programs

- Auto-enrollment for Medicaid/S-CHIP
- Limited expansion of Medicaid to cover more of the people living in poverty in Ohio
- Open S-CHIP to parents of participating kids
- Create a preventive/primary care program for all uninsured residents of the state
- Consider a “three-share” model for workers in small companies

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## Approaching Coverage for All Residents

- Individual responsibility to be insured
- Further expansion of Medicaid and S-CHIP
- Insurance exchange
- Further insurance market reforms
- Require employers to offer cafeteria plans
- Develop a financing plan to which all players contribute

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## Next Steps

- The next step is to refine a set of policy reforms
- This can be followed by formal modeling
- The modeling will show how many people would be covered for each option and the cost
- It will also show that different options yield very different degrees of coverage and cost
- The modeling will show unintended side effects and the tradeoffs across options
- The impact on the Ohio economy can be shown

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## Conclusion

- The problem of the uninsured is serious
- It won't just go away or be fixed with “magic bullet”
- The cost of neglecting the problem is quite high
- A range of viable policy options can be found
- The ones offered here are merely suggestive and illustrative; all can be revised and others added

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## The Difference Between Dialogue and Debate

| Dialogue   | Debate  |
|--|---|
| Dialogue is collaborative: two or more sides work together toward common understanding   | Debate is oppositional: two sides oppose each other and attempt to prove each other wrong   |
| In dialogue, finding common ground is the goal   | In debate, winning is the goal  |
| In dialogue, one listens to the other side in order to understand, find meaning, and find agreement                            | In debate, one listens to the other side in order to find flaws and to counter its arguments  |
| Dialogue enlarges and possibly changes a participant's point of view   | Debate affirms a participant's own point of view  |
| Dialogue complicates positions and issues  | Debate simplifies positions and issues  |
| Dialogue reveals assumptions for reevaluation  | Debate defends assumptions as truth   |
| Dialogue causes introspections on one's own position   | Debate causes critique of the other position  |
| In dialogue, it is acceptable to change one's position   | In debate, it is a sign of weakness and defeat to change one's position   |
| Dialogue is flexible in nature   | Debate is rigid in nature   |
| Dialogue stresses the skill of synthesis   | Debate stresses the skill of analysis   |
| Dialogue opens the possibility of reaching a better solution than any of the original solutions                                | Debate defends one's own position as the best solutions and excludes other solutions  |
| Dialogue strives for multiplicity in perspective   | Debate strives for singularity in perspective   |
| Dialogue affirms the relationship among the participants through collaboration   | Debate affirms one's own strength in opposition to other points of view   |
| Dialogue creates an open-minded attitude: an openness to being wrong and to change   | Debate creates a close-minded attitude: a determination to be right   |
| In dialogue, one submits one's best thinking, knowing that others' reflections will help to improve it, rather than destroy it | In debate, one submits one's best thinking and defends it against challenges to show that is right  |
| Dialogue calls for temporarily suspending one's beliefs  | Debate calls for investing wholeheartedly in one's beliefs  |
| In dialogue, one searches for basic agreements   | In debate, one searches for glaring differences   |
| In dialogue, one searches for strengths in the other position  | In debate, one searches for flaws and weaknesses in the other position  |
| Dialogue involves a real concern for the other person and seeks not to alienate or offend                                      | Debate involves a countering of the other position without focusing on feelings or relationships and often belittles or deprecates the other person |
| Dialogue assumes that many people have pieces of the answer and that together they can put them into a workable answer         | Debate assumes that there is one right answer and that someone has it   |
| Dialogue encourages de-polarization of an issue  | Debate encourages polarization of an issue  |
| In dialogue, everyone is part of the solution to the problem   | In debate, one person or viewpoint wins over the other  |
| Dialogue affirms the idea of people learning from each other   | Debate affirms the idea of people learning individually in competition with others  |
| Dialogue remains open-ended  | Debate implies a conclusion   |